SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0144

For SSA Use Only - Do NOT Complete This Item.	
Name of Wage Earner	Social Security Number
Name of Claimant	Social Security Number
Type of Claim:	

Title II - ☐ Freeze ☐ DIB ☐ DWB ☐ CDB Title XVI - ☐ Disability ☐ Blind ☐ Child

RECONSIDERATION DISABILITY REPORT

PLEASE PRINT, TYPE OR WRITE CLEARLY AND ANSWER ALL ITEMS TO THE BEST OF YOUR ABILITY. If you are filing on behalf of someone else, answer all questions. COMPLETE ANSWERS WILL AID IN PROCESSING THE CLAIM.

PRIVACY ACT: The Social Security Administration is authorized to collect the information on this form under sections 205(a), 223(d) and 1633(a) of the Social Security Act. The information on this form is needed by Social Security to make a decision on your claim. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on your claim and could result in the loss of benefits. Although the information you furnish on this form is almost never used for any purpose other than making a determination on your disability claim, such information may be disclosed by the Social Security Administration as follows: (1) To enable a third party or agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal laws requiring the release of information from Social Security records (e.g., the General Accounting Office and the Veterans Administration); (3) to facilitate statistical research and audit activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security). These and other reasons why information about you may be used or given out are explained in the **Federal Register**. If you would like more information about this, any Social Security office can assist you.

Date Claim Filed

PART I - INFORMATION ABOUT YOUR CONDITION

1. Has there been any change (for better or worse) in your illness or injury since you filed your claim? ..... ☐ Yes ☐ No

   If "Yes," describe any changes in your symptoms.

2. Describe any physical or mental limitations you have as a result of your condition since you filed your claim.

3. Have any restrictions been placed on you by a physician since you filed your claim?..... ☐ Yes ☐ No

   If "Yes," give name, address, and telephone number of the physician and show what kinds of restrictions have been imposed.

4. Do you have any additional illness or injury that you feel we should know about? ☐ Yes ☐ No

   If "Yes," describe the kind of illness or injury and the date that it occurred.

PART II - INFORMATION ABOUT YOUR MEDICAL RECORDS

5. Have you seen any physician since you filed your claim? ..... ☐ Yes ☐ No
If "Yes," provide the following about the physician you last visited:

NAME	ADDRESS *(Include ZIP Code)*
AREA CODE AND TELEPHONE NUMBER	
HOW OFTEN DO YOU SEE THIS PHYSICIAN?	DATE YOU SAW THIS PHYSICIAN

REASONS FOR VISITS

TYPE OF TREATMENT RECEIVED *(Include drugs, surgery, tests)*

6. Have you seen any other physician since you filed your claim?..... ☐ Yes ☐ No
If "Yes," show the following:

NAME	ADDRESS *(Include ZIP Code)*
AREA CODE AND TELEPHONE NUMBER	
HOW OFTEN DO YOU SEE THIS PHYSICIAN?	DATE YOU SAW THIS PHYSICIAN

REASONS FOR VISITS

TYPE OF TREATMENT RECEIVED *(Include drugs, surgery, tests)*

If you have seen other physicians since you filed your claim, list their names, addresses, dates and reasons for visits in Part V.

7. Have you been hospitalized, or treated at a clinic or confined in a nursing home or extended care facility for your illness or injury since you filed your claim?..... ☐ Yes ☐ No
If "Yes," show the following:

NAME OF FACILITY	ADDRESS OF AGENCY *(Include ZIP Code)*
PATIENT OR CLINIC NUMBER	
WERE YOU AN INPATIENT? *(Stayed at least overnight)* ☐ Yes ☐ No IF "YES," SHOW →	DATES OF ADMISSIONS AND DISCHARGES
WERE YOU AN OUTPATIENT? ☐ Yes ☐ No IF "YES," SHOW →	DATES OF VISITS

REASON FOR HOSPITALIZATION, CLINIC VISITS, OR CONFINEMENT

TYPE OF TREATMENT RECEIVED *(Include drugs, surgery, tests)*

If you have been in other hospitals, clinics, nursing homes, or extended care facilities for your illness or injury, list the names, addresss, patient or clinic number, dates and reasons for hospitalization, clinic visits, or confinement in Part V.

8. Have you been seen by other agencies for your injury or illness? ..... ☐ Yes ☐ No
(VA, Workmen's Compensation, Vocational Rehabilitation, Welfare, Special Schools, Unions, etc.)
If "Yes," show the following:

NAME OF AGENCY	ADDRESS OF AGENCY (Include ZIP Code)
YOUR CLAIM NUMBER	
DATES OF VISITS	NAME OF COUNSELOR, SOCIAL WORKER, ETC.

TYPE OF TREATMENT OR EXAMINATION RECEIVED (Include drugs, surgery, tests)

If more space is needed, list the other agencies, their addresses, your claim numbers, dates, and treatment received in Part V.

PART III - INFORMATION ABOUT WORK

9. Have you worked since you filed your claim?..... ☐ Yes ☐ No

If "Yes," you will be asked to give details on a separate form.

PART IV - INFORMATION ABOUT YOUR ACTIVITIES

10. How does your illness or injury affect your ability to care for your personal needs?

11. What changes have occurred in your daily activities since you filed your claim?
(If none, show, "None")

PART V - REMARKS AND AUTHORIZATIONS

12.(a) READ CAREFULLY: I authorize the Social Security Administration to release information from my records, as necessary to process my claim, as follows:

Copies of my medical records may be furnished to a physician or a medical institution for background information if it is necessary for me to have a medical examination by that physician or medical institution. The results of any such examination may be given to my personal physician.

Information from my records may also be furnished, if necessary, to any company providing clerical and administrative services for the purposes of transcribing, typing, copying or otherwise clerically servicing such information. The State Vocational Rehabilitation Agency may also have access to information in my records to determine my eligibility for rehabilitative services.

I understand and concur with the statement and authorizations given above, except as follows (If there are no exceptions, write "None" in the space below. If you do not concur with any part of the above statement, state your objections clearly):

12.(b)	Telephone number where you can be reached:	Best time to reach you:

12.(b) Use this section to continue information required by prior sections. Identify the section for which the information is provided. Note: This section may also be used for any special or additional information which you wish to be recorded.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paper Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number. We estimate that it will take you about 30 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form.

Knowing that anyone making a false statement or representation of a material fact for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal Law, I certify that the above statements are true.

NAME (SIGNATURE OF CLAIMANT OR PERSON FILING ON THE CLAIMANT'S BEHALF)

SIGN HERE ▶	DATE

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address *(Number and street, city, state, and ZIP code)*	Address *(Number and street, city, state, and ZIP code)*

PART VI - FOR SSA USE ONLY - DO NOT WRITE BELOW THIS LINE

Name of Wage Earner	Social Security Number
Name of Claimant	Social Security Number

13. Check each item to indicate whether or not any difficulty was observed:
(Explain all items checked "Yes," in Item 14 below)

Reading:	☐ Yes	☐ No	Using Hands:	☐ Yes	☐ No
Writing:	☐ Yes	☐ No	Breathing:	☐ Yes	☐ No
Answering:	☐ Yes	☐ No	Seeing:	☐ Yes	☐ No
Hearing:	☐ Yes	☐ No	Walking:	☐ Yes	☐ No
Speaking:	☐ Yes	☐ No	Sitting:	☐ Yes	☐ No
Understanding:	☐ Yes	☐ No	Assistive Devices:	☐ Yes	☐ No

Other *(Specify)*: _____

14. If any of the above items were checked "Yes," describe the observed difficulty:

15. Describe fully: General appearance, behavior, any unusual observed difficulties not noted elsewhere, any unusual circumstances surrounding the interviews.

16. Claimant requires assistance ..... ☐ Yes ☐ No

If "Yes," show name, address, phone number, and relationship of interested person.
Also show why claimant requires assistance (foreign-speaking, unable to ambulate, etc.)

17. Capability development appears needed ..... ☐ Yes ☐ No

If "Yes," indicate whether DO will undertake development because it is also developing medical evidence from a special arrangement source. (Show name and address of source.)

18. Is development of work activity necessary?..... ☐ Yes ☐ No

If "Yes," is an SSA-821 or SSA-820-F4 ☐ Pending ☐ In File

19. SSA-3441 Taken By:

☐ Personal Interview
☐ DO/BO ☐ Home ☐ Other _____
☐ Telephone
☐ Mail

Signature of Interviewer or Reviewer	Title	DO, BO, or TSC	Date